Nov 6-9 OSR meeting

discuss this with Bob to find out background

research fees for OSR efforts

where does the money come from? should be

-look through history of COD developing of OSR-

letter similar to that sent

list of committee openings send ahead of time

MEDLINE Laser disk

SOME NOTES, SOME SUMMARIES

from

MEETING

at

NEW ORLEANS

OCTOBER 1986

→best from Petersdorf

- students will contact me if they aren't getting support.

This document contains summaries, excerpts, ideas and conclusions from some of the sessions at the National OSR Meeting. The note taking and organization of this paper has been informal, so perfection may not exist in all areas. The point of providing the paper is to give everyone an opportunity to information which may be beneficial. Hope ya'll enjoy it...

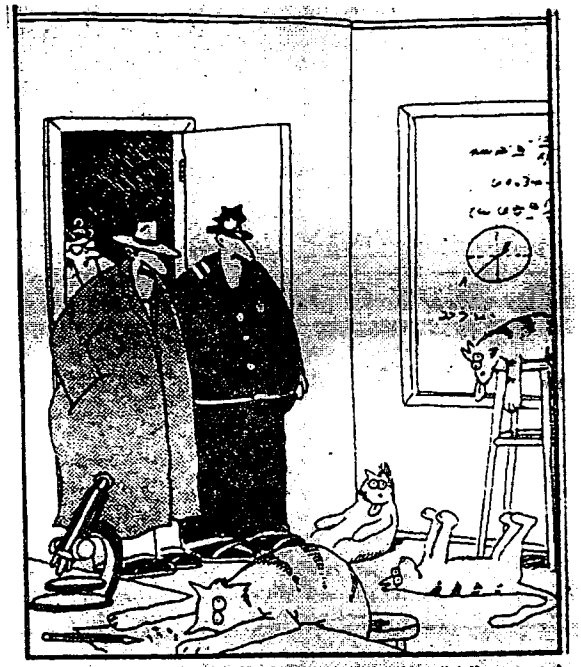
Courtesy of the Southern Region

Informal
Notes/Outline
on the General Session - Friday, October 24, 1986

Dr. Leon Eisenberg, Chairman
Department of Social Medicine and Health Policy
Harvard Medical School

Dr. Leon Eisenberg spoke following his wife, Dr. Carola Eisenberg, who presented ideas about the "Light at the End of the Medical School Tunnel." Dr. Leon Eisenberg then talked about the Trains in the tunnel. I have taken the liberty to reorganize his talk to an outline form.

Jill Tilley Hankins



"Notice all the computations, theoretical scribblings, and lab equipment, Norm. ... Yes, curiosity killed these cats."

FROM "THE FAR SIDE GALLERY 2" BY GARY LARSON (SEE NEW IN PAPERBACK, PAGE 12)

THE TRAINS

COST OF EDUCATION

Problem	Possible Solution
1. Trend is that the cost will increase	1. Change the time allowed for repayment of loans.
2. Applicants will come from families with higher incomes	2. Have a surcharge (of the debt) based on Income Tax Figures
3. What about minorities?	3. Forgiveness of debt if student has selected a field in a needed area
4. Debt may restrict a student's choice of career	

MALPRACTICE CRISIS

Problem	Possible Solution
1. Less than 30% of collected funds from a law suit go to the "injured party."	1. No-fault insurance
2. Cost and fear increases the use of defensive medicine	2. Fees charged when frivalent cases are brought to court
3. Mistrust erodes the doctor-patient relationship	

THE TRAINS

INCOME (decreasing)

Problem	Possible Solution
1. Probably affects applicant pool.	1. Physician's salaries will probably remain higher than most of societies.
2. Remember: Incomes have been increasing rapidly since WWII. Doctors have not always had such high incomes. A leveling off is expected when viewed over a longer period of time reference.	

CLINICAL FREEDOM

Problem	Possible Solution
1. Restriction by health care organizations will affect your decisions about tests, etc. "PRACTICE BY PROTOCOL".	1. This same restriction will help avoid many unnecessary prescriptions and surgeries.
	2. This "protocol" can help you keep your standard of care "up to snuff."
	3. We still need to fight for INDIVIDUAL CARE because cheaper is not the way to determine health.

Preservation of EQUITY AND QUALITY

MAIN THOUGHT: "If we go down, let's go down fighting for patients' rights and not doctors' rights."

THE HEART AND SOUL OF MEDICINE
EVERYDAY ETHICS

Betsy Garrett, M.D.
New Orleans 10/25/86

Caring is still one of the most important things we as physicians can hope to do...

We are in the midst of a time of many questions. This is a time of great energy and rethinking of the basics - from how medicine should be practiced to how physicians should best be trained. This is a time of great opportunity for change...

An essential goal in medicine today needs to be to teach students in such a way that they are raised above the level of a technician and disease fighter, and raised to the level of a healer who is prepared for a life-time of independent learning...

The power of our technology outweighs our wisdom in its application...

The distinctions between disease and illness, and between caring and curing are crucial to the heart and soul of medicine. We must value a person's function as much as we value preservation of life and freedom from disease. Healing is the caring and comforting of a person even when there is no chance for cure or effective treatment...

Obstacles to our becoming caring physicians:

(1) Society. Ever-changing government and insurance regulations have interfered with some traditional doctor-patient relationships and decision making.

(2) Medical education. Students are told to memorize facts. There seems to be little opportunity for analysis or synthesis. In the clinical years, students are trained with "specialized" patients in tertiary care centers. There is a lack of ambulatory training; there is not enough exposure to community hospitals. Students' needs as individuals are often neglected by medical education. Students can easily become cynical and lose their idealism.

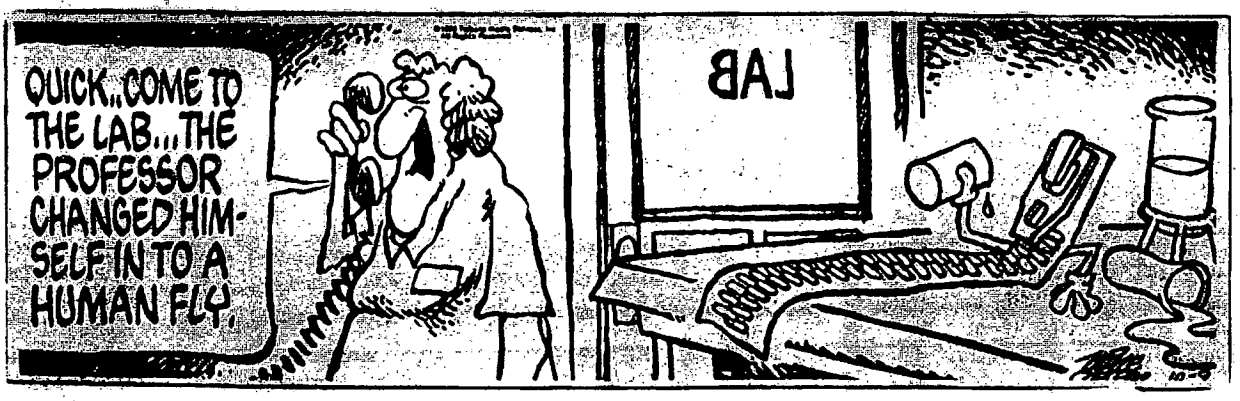
(3) Ourselves. We must learn to recognize our own feelings in order to be able to help our patients best. As students, we often underevaluate our roles in the care of the patient, we feel that we will not add anything significant to the diagnosis or treatment. For this we feel badly. But because we are idealistic and a little naive, and because we are not yet caught up in all of the jargon of disease and the technology, we naturally identify more closely with the patient than the doctor. We will have a more special closeness to the patient's experience now than we ever will again.

Medical training tends to be divided between "hard" subjects (science, facts, numbers, etc.) and "soft" subjects (psychology, patient-doctor relationships, philosophy of medicine). The "hard" is a key foundation, but it changes with time. The "soft" subjects have greater longevity. Too often the "hard" is emphasized at the expense of the "soft". A balance is necessary...

It takes deep inner strength to confront the demands, emotional highs and lows, and self-discovery that are all part of medical training. We must find time for our own special needs as individuals...

We must never allow knowledge to get in the way of our relationships with our patients. Ultimately, it is our respect for the human soul that determines the worth of our science...

Provided by Billy Rice
BOWMAN GRAY



In the seminar "Giving Human Value Courses a Clinical Focus," Reverend Skeel and Dr. Thomasma stressed the benefits of teaching ethical decision making during the clinical years of medical education. Among these benefits are: 1) that students take ethics courses more seriously, 2) that students 'get more' out of such courses than those taught in the second year, and 3) that students see the application of ethical decision making.

Reverend Skeel and Dr. Thomasma suggested that some kind of ethical decision making be taught during the first year and then again in the clinical setting during the third and fourth year. At MCO, where Reverend Skeel is on faculty, she conducts 'ethics rounds' where a medical or surgical patient is presented with discussion of the ethical issues surrounding the patient's case. Reverend Skeel reports that ethics rounds (and adjunct conferences) have been a big success. She adds that students who "blew off" ethics during the years of instruction in the basic sciences tell her they are sorry they did so after experiencing ethics in the clinical years.

Reverend Skeel also mentioned the following signs of progress, many of which stem directly from improved integration of human values courses in the clinical years, including:

- o Expanded use of interactional, small group teaching
- o Better acceptance of human values programs by basic science faculty
- o Greater willingness on the part of everyone to raise values questions
- o Human values program faculty regularly giving hospital conferences and serving on institutional committees
- o Greater number of clinical faculty engaged in human values teaching components
- o Improved coordination of clinical and basic science curricula

Moreover, curriculum-building is evident at schools which have nurtured their human values programs over a number of years and at schools with newer programs where, during third- and fourth-year courses, faculty can assume a foundation laid during pre-clinical years.

Among the observations possible from an examination of the above and other information obtained from surveys and interviews are:

- Programs based in the medical humanities continue to grow and to demonstrate their relevance to the goal of improving students' clinical skills.

- Students need to experience significant patient contact during their first year, encouragement to examine their own values, and exercises which integrate the basic and clinical sciences.

- Human values components can originate in any department but appear to have the most success when they combine the strengths of more than once discipline.

- In order to be effective, human values programs need a practical orientation. Using clinical cases in problem-solving exercises and small group discussions led by clinicians, faculty can ground their programs in students' immediate emotional experiences as developing health care professional and in the clinical realities they will face.

For more information or to discuss this Project, please contact: Janet Bickel, Division of Student Programs (202/828-0575). Please sign a sheet available at this Exhibit Booth to receive a full report of the Project when it becomes available. Other discussion headings are faculty characteristics and faculty development efforts, barriers to progress, evaluating human values teaching, and human values teaching programs for residents.

Dan Shapiro
Emory University

-- Preventive Medicine Seminar --

The purpose of the seminar in preventive medicine was to present information on the state of this "stepchild" of modern allopathic practice today. A panel of enthusiastic speakers involved in teaching and working in the field offered their views about preventive medicine. Dr. Kevin Patrick, Director of the Preventive Medicine Residency Program at the University of California-San Diego, spoke about the four areas involved in a preventive health residency program: occupational health, aerospace medicine, public health and general preventive medicine. Common to training in most preventive medicine residencies is a clinical period of at least one year, an academic year to obtain an MPH or equivalent, and a practicum year. Areas of study include biostatistics, epidemiology, planning, administration and health care organization. Dr. James Carter, Assistant Professor in the Department of Family Medicine at Morehouse School of Medicine, spoke of the need to counsel patients not only about their acute illness or suboptimal health, but also about plans of action for long term optimal health. He advised physicians to stress to the patients self-responsibility for their own health; nutrition; physical fitness; stress management; social, economic and political factors; and their spiritual development. Dr. Sapenfield, an Epidemic Intelligence Service Officer from the CDC, spoke about the development of EIS and the exciting possibilities of a career or short time experience with the CDC. Each of the presenters was positive and encouraging about the possibility of meaningful careers in preventive medicine.

The highlight of the afternoon's seminar was a presentation by Dr. Andrew Weil, from the Division of Social Perspectives at the University of Arizona School of Medicine, entitled "Alternatives to High Tech Health Care." Expressing mild disagreement with the panelists over the meaning of preventive medicine - "more than sanitation and jogging" -

Dr. Weil made the centerpiece of his lecture a painstaking history which he took from a volunteer in the audience. Dr. Weil explained that in a thorough history what the patient does, in effect, is diagnose his own illness. Unless allopathic measures are clearly called for - surgical procedures, disease-specific antibiotics, and the like - what Dr. Weil prefers to do with his patients - once the history has pinpointed the nature of the problem - is encourage the natural healing powers of the mind and body through the use of a variety of non-invasive therapies, including, in some cases, cranial-sacral manipulation, the use of herbal remedies, diet and exercise. Dr. Weil is quite convinced - and is extraordinarily convincing in presenting his beliefs - that modern allopathic medicine has failed to consider the mind as a significant and powerful force in the healing process. As an alternative to high tech medicine, which he is by no means opposed to but which he feels the modern physician may rely too heavily upon, he posits humanistic alternatives - when called for - which enlist more fully the willing compliance of the patient.

Michelle Greenway-Birdseye
Mercer University
School of Medicine

Staying Healthy
(second half)
Alternatives to High-Tech Health Care
Andrew Weil, M.D.
by Jim Stout, Pediatric Resident

Andrew began the session with a discussion that was a capsule summary of his philosophy of health care. These points were addressed during the General Seesion speech Saturday night by Andrew and I won't go into detail here. In general, there are three main areas in which Andrew's approach differs from how we are taught to practice medicine, that he covered in this session, which I will summarize.

First, his emphasis is on avoiding disease--that is, diet and other life-style interventions that could play a part in preventing illness. Although this is occasionally paid lip service in our medical schools, I doubt that many of us have been exposed to good education methods and strategies to change patients' (not to mention our own) unhealthy behavior.

Second, Andrew uses what can only be described as an eclectic referral system. Over the years he has accumulated a network of alternative practitioners that he feels offers certain types of health care to his patients not available by our present system. Andrew has studied more varieties of health care than I knew existed, including naturopathy, traditional Chinese medicine, homeopathy, herbalism, oseteopathy, etc. Certainly the most difficult task for him is to wade through the quacks and charlatans in order to find those alternative practitioners that have something uniquely beneficial to offer. In our credential-and license-oriented system (which I might add, I am very thankful for) we tend to treat those from outside our dominant system as having nothing worthwhile to offer. Unfortunately, this prejudice blinds us to those alternative techniques that work.

Thirdly, Andrew emphasizes the history much more than we are used to, paying attention to such items as major childhood events, birth history, diet, stress factors, relationships, exercise, use of body, type of occupation, etc. There is nothing magical about his questions. In fact, I recall using many of them during my introductory clinical course, struggling through those first clumsy two hour historys and physicals. Most of these questions I was directly or indirectly taught to leave out of our work-ups.

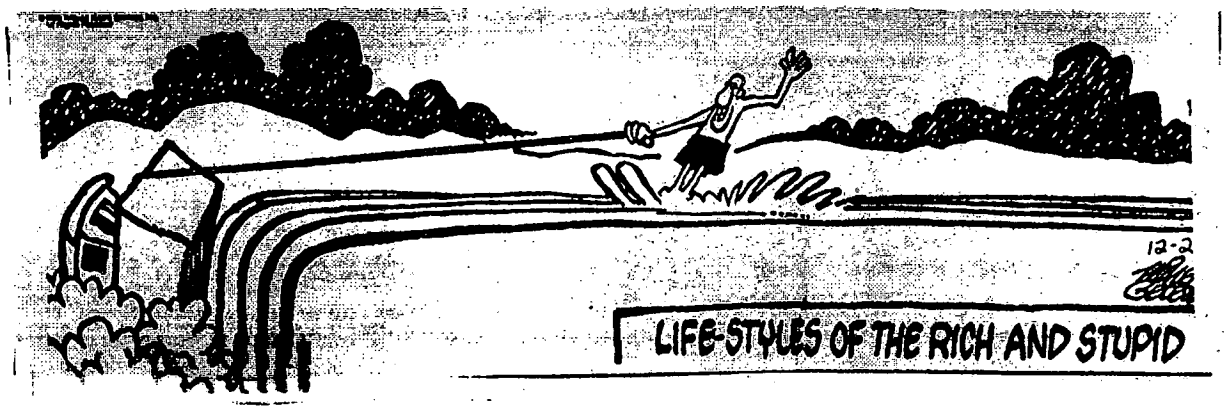
The second phase of the discussion was an interview with a medical student from the audience. The patient presented with a complaint of well-localized back pain not associated with trauma. Many of Andrew's questions apparently had nothing to do with the problem, although occasionally the rationale became apparent later in the interview. The interview ended with a referral to an osteopathic physician in the patients' hometown. Tune in next newsletter for the conclusion of the case.

The remainder of the session was spent on questions and answers. The question that stuck in my mind was:

Q) How can we find time to learn about these alternative methods when there isn't even enough time to learn abouth allopathic medicine?

A) Obviously, there's no real answer to this one, although Andrew pointed out that to at least be conversant in these different techniques will give you a competitive advantage as patients become increasingly interested in pursuing options and being more responsible for their care.

All in all, it was a good, stimulating session and led to a lively discussion afterwards.



COMMUNITY ORIENTED PRIMARY CARE

H. Jack Geiger, M.D.
Arthur Kaufman, M.D.

The main concept is first to get a solid epidemiological grasp on the health problems of a defined area's population, then to design a primary care preventive medical approach to provide solutions to that community's problems.

One of the early long-term projects with a well developed data base involves a string of community health centers operated by the University of Natal in South Africa. While this approach lends itself well to chronically underserved third world conditions, plenty of regional health care needs and opportunities exist in the United States. Smaller communities and rural areas, as well as urban neighborhoods and ethnic enclaves, make well suited models. In this country a collection of approximately 20 group practices with a developed data base and uniform record keeping procedures has published relevant information under the name of the American Central Practice Network. The United States Health, Education, and Welfare Department (possibly through the Office of Economic Opportunity) has been involved in projects along these lines as well.

In actual operation, a group of health professionals, mostly involved in primary care, are given responsibility for a defined community. The health situation of the area, from actual disease occurrence to environmental, economic and life-style factors to the condition of the local health care system is assessed using epidemiological and statistical tools. Considerations of cost effectiveness and the practical aspects of changing health habits allow tailoring of a long-term preventive medicine program. One key statistical concept used in evaluation is the years of productive life lost because of a health problem. Also one of the limitations on the use of urban areas is their generally higher turnover of residents which hinders the follow-up necessary for judging the effectiveness of the programs.

Dr. Kaufman referred to the film Learning Medicine: The New Mexico Experiment to show how this concept can be exercised in medical education. He also pointed out how small scale pilot projects for medical students work well when based on a captive population such as classes of school children. This makes tracking patients much more simple. Students also get excited about it at this level because of the tangible results in prevention of such obvious problems as teen pregnancy, cigarette smoking, and other areas.

Dr. Geiger described a nine-week elective program he is involved with in New York. Teams of three students are assigned an urban neighborhood. Using census data and previously gathered information

from a variety of governmental and academic sources, they construct a community profile. This includes data on housing, employment, recreation, education level, health resources, mobidity and mortality, etc. Then the prevention points are targeted and programs are designed.

Discussion brought out the following points. Tufts university stresses learning descriptions of and access to the various resource agencies and organizations in their area. University of Connecticut students have a prepared list of organizations and services in their area. University of Massachusetts periodically holds a very successful fair so representatives from all the various groups can present information to local physicians and students.

Additional contacts for funding and design of projects and electives:

Residency Program in Social Medicine
3412 Bainbridge Avenue
Bronx, NY 10467 (212) 920-5521

Smith-Kline Beckman
National Fund for Medical Education
Marla J. Driscol (203) 278-5070 Deadline March 1

American Medical Student Association Foundation
Health Promotion and Disease Prevention Project
Kathie Westpheling (703) 620-6600
1890 Preston White Drive
Reston, VA 22091
Funding still pending for '87-89 Deadline March

H. Jack Geiger, M.D.
Professor of Community Medicine
130 8th Street at Covenant Avenue
New York, New York 10031

Arthur Kaufman, M.D.
Director of Family Medicine
University of New Mexico
Albuquerque, New Mexico 87131

Clayton Ballantine

Problem-Based Learning 10/26

Dr. William Shragge began this session with a historical review of problem based learning (PBL) which began when educators realized a dichotomy existed between the process/content of the Basic Sciences and the skills needed for the clinical years. He listed three fundamental premises behind PBL: (1) The student is a mature individual, responsible for his/her own education; (2) Medicine entails a "lifelong continuum of self-directed knowledge"; (3) No real defined core of knowledge exists for the mastery of medicine. As time passed, a learning model evolved:

> The student is presented with problems that are integrated, "non-clean".
>
> Learning is then based on skills of solving those problems in a small group with faculty as FACILITATORS only.
>
> Emphasis is on the problems serving as a jumping off point for learning ... and then the process evolves into a solution of the problems.

The thrust of PBL, according to Shragge, is "learning skills at problem management." And the question to ask yourself is, "Are you dynamic and active, or a little pot being filled?"

To demonstrate an example of problem based learning, the large group then divided into small groups, each with a faculty facilitator. We were all given a case (included) and we began generating hypotheses. My group facilitator was a Family Medicine M.D. from New Mexico who is a "Tutor" for their program. He spends eight weeks with a group and he listed some of the dynamics of the small group: (1) Everyone at some point will stop knowing the answers, (2) The reasoning process is crucial, (3) The point is to identify what you know or don't know, and (4) The small group helps students to become more comfortable with saying, "I don't know."

Kim Dunn of Houston, now chair-elect, told the group that the AAMC has taken PBL as a project that will be student centered. The project involves developing a workshop (goal is 1987/ summer) for Deans, faculty and students to showcase PBL. She challenged us to:

1) Start educating sympathetic faculty/Deans about PBL -- that it exists and that you are interested in it and this workshop.
2) Write down any ideas you have about PBL and send them to Janet Bickel, c/o Association of American Medical Colleges; One Dupont Circle, N.W.; Washington, D.C. 20036.

Jill Hankins, M-4
University of Arkansas

Problem-based Learning Session

THE JAUNDICED MAN

CASE-107

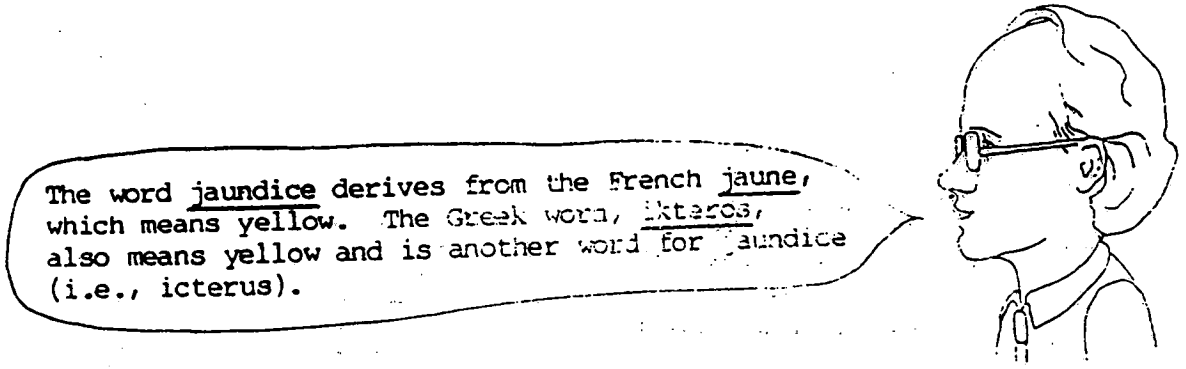
The Jaundiced Man

Jason LaMark, a 32-year-old married computer programmer, presents to your office with a 2-day history of jaundice.

Reader's Tasks

Take out a piece of paper and write down a list of possible causes of jaundice (hypotheses).

Explain the mechanisms by which each hypothesized cause would result in jaundice.



SUMMARY OF SOUTHERN SURVEY CONCERNING NATIONAL MEETING AT NEW ORLEANS

Perhaps the most overwhelming consensus of the group was that New Orleans was an excellent location for the meeting, despite the expense.

In response to the first survey question, "What have you enjoyed most ... ?", the chance to interact with other medical students was the most frequently mentioned item. Several OSR members commented that they enjoyed discovering that other students were concerned about medical education and that they were concerned about many of the same issues. The Problem Based Learning session was the second most mentioned item. Of the speakers, Andrew Weil and the Eisenbergs (General Session) were enjoyed most. Other items enjoyed: the diversity of the topics, becoming aware of issues, efficiency of business meetings, bulletin board for information exchange, ethics sessions and, of course, Bourbon Street.

Specific information found to be the most useful was (listed in decreasing order of frequency): (1) Problem Based Learning session; (2) Ethics session; (3) New Mexico Experiment; (4) Financial aid update; (5) Preventive medicine; and (6) Minority affairs issues. Others listed included National Boards update, emerging health care delivery systems, community health projects, and "getting info on the Spring meeting."

Constructive criticism on . . .

1) Program Content
   a. Needed to present more information on the New Mexico Experiment (more specifically, how to implement).
   b. Too much repetition in some cases.
   * c. Needed to be presented with more specific and concrete ideas to take home "that students in my school can use now."
   d. Needed more information about legislation, malpractice insurance, and how to implement problem based learning.

2) Small Group Sessions
   a. Would like to see repeated sessions to offer more chances to see different programs.
   b. Handouts would add "teeth" to sessions.
   c. "The Emerging Health Care Delivery Systems" needed a more basic overview of mechanics of "Health Care Delivery" (definitions, etc.)
   d. Need more organized small groups.

2) Small Group Sessions (continued)
   e. Need more "problem solving" sessions and more interaction about problems.
   f. More emphasis on networking.
   g. Make minutes of meetings available.

3) Organization of Activities and Time
   a. Meetings should attempt to start and end on time.
   b. Not enough time spent on items important to GSA/AAMC.
   c. Needed another day - or more time.
   d. Needed more free time during the day.
   e. Too structured.

Jill Hankins
Southern Chairperson
University of Arkansas